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Office of Administrative Law Judges
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Issue Date: 26 February 2007

In the Matter of:

M.A., on behalf of
and Survivor of W.A.,
Claimant

Case No.: 2003-BLA-05220

v.

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

Appearances:

Brent Bowker
Appalachian Citizens Law Center
Prestonsburg, Kentucky
For the Claimant

Donna Sonner, Esq.
U.S. Department of Labor
Office of the Solicitor
Nashville, Tennessee
For the Director, OWCP

Before: Alice M. Craft
Administrative Law Judge

DECISION AND ORDER AND AWARDING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. § 901 et seq. The Act and implementing regulations, 20 CFR Parts 410, 718, 725 and 727, provide compensation and other benefits to living coal miners who are totally disabled due to pneumoconiosis and their dependents, and surviving dependents of coal miners whose death was due to pneumoconiosis. The Act and regulations define pneumoconiosis, commonly known as black lung disease, as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. 30 U.S.C. § 902(b); 20 CFR § 718.201 (2006). In this case, the Claimant is pursuing a claim on behalf of her deceased husband ("the Miner"), who filed a claim alleging that he was totally disabled due to pneumoconiosis. In addition, the Claimant is pursuing a claim on her own behalf, alleging that she is the surviving dependent of the Miner, whose death was due to pneumoconiosis.

I conducted a hearing on this claim on March 30, 2005, in Knoxville, Tennessee. Both parties were afforded a full opportunity to present evidence and argument, as provided in the Rules of Practice and Procedure before the Office of Administrative Law Judges, 29 CFR Part 18 (2006). At the hearing, the Claimant and Dr. Curtis Sexton testified. Transcript ("Tr.") at 12-15; 16-21. Director's Exhibits ("DX") 2-27 and Claimant's Exhibits ("CX") 2-6 were admitted into evidence without objection, subject to holding the record open to allow the Director to obtain responsive evidence to two of the exhibits. Tr. at 9, 12. DX 1 was admitted provisionally, as it is admissible in the Miner's claim, but the parties were uncertain whether it contained medical evidence which exceeded the limitations found in 20 CFR §725.414 in the context of the Survivor's claim. Tr. at 8. There is no CX 1, as the Claimant had used that designation for her Evidence Summary Form, which was accepted for the record, but not given an exhibit number. Tr. at 11-12. The record was held open for the Director to obtain additional evidence, for the parties to confer on the admissibility of DX 1 in the Survivor's claim, and for the parties to submit closing arguments. DX 28 and 29 were admitted during a telephone conference held on July 14, 2005. Tr. at 6-7. The parties agreed that the entirety of DX 1, as well as the evidence from the Survivor's claim, can be considered in the Miner's claim, but as to the Survivor's claim, only the medical evidence designated by the Director in his Evidence Summary Form, would be considered. Tr. at 7-10. *See* Order on Telephone Conference issued July 14, 2005. This restriction does not apply to records of hospitalizations or treatment for pulmonary or respiratory disease. *See* 20 CFR § 725.414(a)(4). The Director filed a revised Evidence Summary Form under cover of letter dated May 27, 2005; the Director did not designate any evidence from DX 1 to be considered in the Survivor's claim. Both parties filed closing briefs, and the record is closed.

In reaching my decision, I have reviewed and considered the entire record pertaining to each claim before me, including all exhibits admitted into evidence for the purpose of the Miner's or the Survivor's claim, respectively, the testimony at hearing and the arguments of the parties.

PROCEDURAL HISTORY

The Miner filed his initial claim on July 9, 1970. DX 1 (DX 22). This claim was filed with Social Security Administration, which was later referred to the Department of Labor and combined with the Miner's claim filed on December 2, 1976. The claim was denied by Administrative Law Judge Frank Marcellino by decision and order dated June 19, 1984. Judge Marcellino found that the Miner had established nine years of coal mine employment and pneumoconiosis but failed to establish total disability.

On April 18, 1988, the Miner filed a second claim. DX 1 (DX 23). The District Director denied this claim on July 21, 1988, and the Claimant took no further action on it.

A third claim was filed on May 20, 1991. DX 1 (DX 1). The District Director denied this claim. Next, the Miner requested a modification, which the Director also denied. The Miner requested a hearing before the Office of Administrative Law Judges. Administrative Law Judge Paul Teitler denied benefits by decision and order dated March 2, 1995. Judge Teitler found that the Miner had established 6 years and 3 months of coal mine employment but that the Miner had failed to show that he suffered from pneumoconiosis.

The instant Miner's claim was filed on August 20, 2001. DX 8. On October 7, 2001, before the Department of Labor evaluation could take place, the Miner died. DX 12. The Claimant then pursued the claim on his behalf. The District Director denied benefits in an Proposed Decision and Order dated September 24, 2002. DX 24. The District Director found that the Miner had 6 years of coal mine employment, and that he suffered from pneumoconiosis due to exposure to coal dust, but that he was not disabled by the disease. DX 24. This finding was sufficient to demonstrate a material change in conditions, as Judge Teitler had found no pneumoconiosis, but the District Director denied benefits because not all elements for entitlement were established. The Claimant filed an appeal on October 11, 2002. DX 26.

In the meantime, on December 28, 2001, the Claimant had also filed her claim for survivor's benefits. DX 5. The District Director denied this claim in a Proposed Decision and Order dated September 24, 2002. DX 25. The District Director found the Miner suffered from pneumoconiosis, and that the disease was caused by coal mine employment, but also found that the evidence did not show that the Miner's death was due to pneumoconiosis. The Claimant appealed this decision on October 11, 2002. DX 26.

Both claims were transferred to the Office of Administrative Law Judges on December 6, 2002. DX 27.

APPLICABLE STANDARDS

The Miner's Claim

This claim relates to a "subsequent" claim filed on August 20, 2001. Because the claim at issue was filed after March 31, 1980, and after January 19, 2001, the effective date of the current regulations, the current regulations at 20 CFR Parts 718 and 725 apply. 20 CFR §§ 718.2 and 725.2 (2006). Pursuant to 20 CFR § 725.309(d) (2006), in order to establish that the Miner was entitled to benefits, the Claimant must demonstrate that "one of the applicable conditions of entitlement … has changed since the date upon which the order denying the prior claim became final" such that the Miner met the requirements for entitlement to benefits under 20 CFR Part 718. In order to establish entitlement to benefits under Part 718, the Claimant must establish that the Miner suffered from pneumoconiosis, that his pneumoconiosis arose out of his coal mine employment, and that his pneumoconiosis was totally disabling. 20 CFR §§ 718.1, 718.202, 718.203, 718.204, and 725.103 (2006). I must consider the new evidence and determine whether the Claimant has proved at least one of the elements of entitlement previously decided against the Miner. In this case, the Director has conceded that the Miner had simple pneumoconiosis arising from his coal mine employment. This concession establishes a change in one of the applicable conditions of entitlement, as Judge Teitler found in the Miner's previous claim that he had not established that he had pneumoconiosis. For this reason, I must consider whether all of the evidence establishes that he was entitled to benefits. *Sharondale Corp. v. Ross*, 42 F.3d 993 (6th Cir. 1994). Evidence admitted in the prior claim may be considered notwithstanding the limitations on the introduction of evidence contained in 20 CFR § 725.414 (2006). 20 CFR § 725.309(d)(1) (2006). Moreover, no findings in the prior claims are binding, unless a party failed to contest an issue, or made a stipulation in a prior claim. 20 CFR § 725.309(d)(4) (2006).

Survivor's Claim

A surviving spouse is entitled to benefits if the miner died due to pneumoconiosis which arose out of coal mine employment. See 30 U.S.C. § 901; 20 CFR §§ 718.205 and 725.212(a)(3) (2006). The Claimant must first establish that the miner suffered from pneumoconiosis. *See Trumbo v. Reading Anthracite Co.,* 17 B.L.R. 1-85 (1993). The Sixth Circuit, in which this claim arises, has held that any condition that hastens the miner's death is a substantially contributing cause of death. *Brown v. Rock Creek Mining Corp*., 996 F.2d 812 (6th Cir. 1993).

The limitations on the introduction of evidence contained in 20 CFR § 725.414 (2006) apply to both the Miner's and the Survivor's claims. Although medical evidence from a Miner's previous claims is admissible in a subsequent miner's claim, it is not automatically admissible in the Survivor's claim. *Church v. Kentland-Elkhorn Coal Corp.*, BRB Nos. 04-0617 BLA and 04-0617/BLA-A, ALJ No. 2003-BLA-5484, electronic slip op. (PDF) at 5 (BRB April 8, 2005).When a Miner's claim and a Survivor's claim are consolidated, the parties must designate which evidence is to be considered in each claim in accordance with the limitations found in 20 CFR § 725.414. *Keener v. Peerless Eagle Coal Co.*, BRB No. 05-1008 BLA, ALJ No. 2004-BLA-6265, electronic slip op. (PDF) at 9-11 (BRB Jan. 26, 2007).

ISSUES

The issues contested by the Director in the Miner's claim are:

1. Whether the Miner was totally disabled.

2. Whether the Miner's disability was due to pneumoconiosis.

DX 27; Tr. at 5. The District Director marked on the CM 1025 that whether the evidence establishes a change in conditions since denial of the prior claim was also at issue. However, the Director conceded that the Claimant had simple pneumoconiosis, *see* the Director's Response to Claimant's Supplemental Brief filed under cover of letter dated August 4, 2005, which also establishes a change in conditions. In addition, the District Director marked modification as an issue on the CM 1025; however, review of the file discloses that the Miner's claim does not involve a request for modification. The parties stipulated that the Miner had six years of coal mine employment. Tr. at 5.

The only issue contested by the Director in the Survivor's claim is whether the Miner's death was due to pneumoconiosis. DX 27; Tr. at 5.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Factual Background and Hearing Testimony

The Miner testified at a previous hearings held in 1984 and 1994. DX 1. He had an eighth grade education. DX 3. His wife was his only dependent.

The Miner began working in the coal mines in 1936 and continued off and on until 1952 when the mine he was working in closed. DX 3, 6. In his testimony he said he worked in the

mines as much as 15 years; however, not all of his coal mine employment is documented in the Social Security records. The parties stipulated to 6 years of coal mine employment. Tr. at 5. The Employment History and Social Security records support this stipulation. DX 2, 3. His last coal mine employment was in Tennessee. DX 2. Therefore this claim is governed by the law of the Sixth Circuit. *Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1989) (en banc).

The medical records and the Miner's testimony suggest that he smoked cigarettes for 40 to 50 years at a rate of a half pack to one pack per day.

The Claimant testified at the hearing held March 30, 2005. She testified that she married the Miner in 1948, was never divorced from him, and has not remarried since his death. She said he was a custodian at an elementary school from 1966 to 1984; he retired from that job. She also testified that the Miner had heart bypass surgery in 1996 and was on medication for his heart condition. She confirmed that he was a smoker.

Dr. Craig Sexton also testified at the 2005 hearing. His testimony is described below with the other medical opinion evidence.

Medical Evidence

Autopsy (Considered in Both Claims)

An autopsy may be the basis for a finding of the existence of pneumoconiosis. A finding of anthracotic pigmentation is not sufficient, by itself, to establish pneumoconiosis. 20 CFR § 718.202(a)(2) (2006). Section 718.106(a) provides that an autopsy report shall include a detailed gross macroscopic and microscopic description of the lungs or visualized portion of a lung. If a surgical procedure was performed to obtain a portion of a lung, the evidence should include a copy of the surgical note and the pathology report. Greater weight may be accorded to a physician who performs the autopsy over one who reviews the autopsy slides. *Peabody Coal Co. v. Shonk*, 906 F.2d 264, 269 (7th Cir. 1990); *U.S. Steel Corp. v. Oravetz*, 686 F.2d 197, 200 (3d Cir. 1982); *Gruller v. Bethenergy Mines, Inc*., 16 B.L.R. 1-3 (1991); *Similia v. Bethlehem Mines Corp*., 7 B.L.R.1-535, 1-539 (1984); *Cantrell v. U.S. Steel Corp*., 6 B.L.R. 1-1003, 1-1006 (1984).

Dr. Harrison performed an autopsy on the Miner and provided a report dated October 23, 2001. DX 13; CX 4. Dr. Harrison is board certified in anatomic and clinical pathology. He provided a detailed report of his macroscopic findings of the Miner's lungs, noting particularly firm to calcified black lymph nodes ranging up to 1.8 cm in greatest dimension in the left lung, and up to 1.5 cm in the right lung. In addition to the tumor, microscopic examination of the right lung revealed "extensive emphysema with several bullae," and "marked anthracosis and patchy fibrosis in a nodular pattern." Examination of the slides under polarized light revealed "numerous birefringent needle-like particles consistent with silica in the areas of anthracosis and fibrosis." The left lung showed cancer and "marked emphysema with numerous aggregates of anthracotic pigment associated with fibrosis. There is pronounced pleural fibrosis with nodular fibrosis associated with anthracotic pigment and birefringent particles consistent with silica. Left hilar lymph nodes showed similar finding of fibrosis, anthracotic pigment and silica.
Dr. Harrison's final diagnoses were:

I. Poorly-differentiated non-small cell carcinoma, lung. …

II. Marked anthracosilicosis with nodular fibrosis, bilateral lungs.

A. Marked emphysema with bleb formation, bilateral lungs.

B. Nodular fibrosis with abundant anthracotic pigment and silica particles involving hilar lymph nodes.

III. Severe, calcific coronary atherosclerosis. …

Dr. Harrison wrote a letter dated August 22, 2002, to Dr. Sexton, explaining his findings in relation to the size of lung lesions he measured. In his letter he stated,

> … I believe it is important to understand the size of a lung lesion measured by a pathologist during gross examination represents an approximation. The recorded size of any lesion should be considered a minimum rather than the exact size for the following reasons:
>
> A) The size of any lesion depends upon where it is sectioned. If the lesion is not sectioned exactly through the middle of its longest axis, the gross measurement will be smaller than the true size of the lesion.
>
> B) Lesions may be larger radiographically than when palpated or visualized …
>
> C) It is also possible that the tumor mass has encompassed one or more lesions …
>
> I hope this letter is helpful in explaining why the measurements I obtained at autopsy may not correlate well with the radiographic findings. In my opinion, the radiographic measurement of lesions is more accurate than those described by gross examination by a pathologist …

DX 14.

Dr. Perper, another pathologist, reviewed the autopsy report and slides on behalf of the Director. Because his report encompassed more than just the autopsy, his opinion is discussed below along with other medical opinions.

Biopsies

Biopsies may be the basis for a finding of the existence of pneumoconiosis. A finding of anthracotic pigmentation is not sufficient, by itself, to establish pneumoconiosis. 20 CFR § 718.202(a)(2) (2006). Section 718.106(a) provides that a biopsy report shall include a detailed gross macroscopic and microscopic description of the lungs or visualized portion of a lung. If a surgical procedure was performed to obtain a portion of a lung, the evidence should include a

copy of the surgical note and the pathology report. The Benefits Review Board has held, however, that the quality standards are not mandatory and failure to comply with the standards goes only to the reliability and weight of the evidence. *Dillon v. Peabody Coal Co*., 11 B.L.R. 1-113, 1-114 (1988); *see Dagnan v. Black Diamond Coal Mining Co*., 994 F.2d 1536, 1540-1541 (11th Cir. 1992). Section 718.106(c) provides that "[a] negative biopsy is not conclusive evidence that the miner does not have pneumoconiosis. However, where positive findings are obtained on biopsy, the results will constitute evidence of the presence of pneumoconiosis." There are reports of two bronchoscopies with biopsies taken in connection with the Miner's medical treatment in evidence in this case.

Dr. Jordan performed a bronchoscopy and biopsy on the Miner and prepared a report dated July 1, 1994. DX 1, CX 6. Dr. Jordan said the pathology report found that the Miner suffered from COPD and there was no evidence of CWP. The report by the pathologist, Dr. Eatherly, diagnosed "pulmonary parenchyma with mild to moderate interstitial fibrosis. No evidence of neoplasm." This biopsy has been considered only in the Miner's claim.

Dr. Parrish performed a bronchoscopy and biopsy of the Miner's right lung on June 20, 2001, because of the Miner's hemoptysis and right upper lobe mass. Dr. Eatherly prepared cytology and surgical pathology reports of the biopsied material. The cytology diagnosis was undifferentiated large cell carcinoma. The surgical pathology diagnosis was non-small cell carcinoma. The results of this biopsy have been considered in both pending claims. CX 6.

Chest X-rays Admitted into Evidence in the Miner's Prior Claims (Considered Only in the Miner's Claim)

Chest x-rays may reveal opacities in the lungs caused by pneumoconiosis and other diseases. Larger and more numerous opacities result in greater lung impairment. The existence of pneumoconiosis may be established by chest x-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. Small opacities (1, 2, or 3) (in ascending order of profusion) may classified as round (p, q, r) or irregular (s, t, u), and may be evidence of "simple pneumoconiosis." Large opacities (greater than 1 cm) may be classified as A, B or C, in ascending order of size, and may be evidence of "complicated pneumoconiosis." A chest x-ray classified as category "0," including subcategories 0/-, 0/0, 0/1, does not constitute evidence of pneumoconiosis. 20 CFR § 718.102(b) (2006).

In the Miner's prior claims, multiple readings of five x-rays taken between 1971 and 1992 were admitted into the record. Only two (the x-rays taken April 15, 1980, and June 18, 1991) were read as positive, 1/1, by single readers. There were more negative readings by well qualified readers of both of those x-rays. Two x-rays taken in 1994 were read as showing chronic obstructive pulmonary disease or very mild interstitial disease, but were not classified as required by the regulations. Those x-rays are neither positive nor negative. The overwhelming weight of the x-ray evidence in the Miner's previous claims was negative for pneumoconiosis.

Chest X-ray Readings Submitted in Connection with the Pending Claims (Considered in Both Claims)

Only two readings of one x-ray were identified by the parties in their Evidence Summary Forms for consideration in the pending claims. An x-ray taken August 30, 2001, was read as

positive for complicated pneumoconiosis, category A, by Dr. Parrish, who has no special qualifications for reading x-rays, and as negative for pneumoconiosis by Dr. Barrett, who is a board-certified radiologist and a NIOSH certified B Reader. As the better qualified reader found the x-ray to be negative, I find that it is negative.

CX 6 contains several chest x-ray reports by Dr. Parrish and others, taken during the Claimant's treatment. None of the individual x-rays were classified for pneumoconiosis. On June 20, 2002, after the Miner's death, Dr. Parrish reported that he had reviewed several x-rays from the hospital beginning with one taken January 31, 2001. He said there was evidence of pleural thickening, and diffuse opacities in both lower lung fields that he would grade as 1/1, and a few greater than one cm. There is no indication how many or which x-rays Dr. Parrish reviewed, and the Claimant did not identify these x-rays or any of the other x-ray reports on her Evidence Summary Form. As a result, in reaching my decision, I have not considered these x-ray reports, or Dr. Parrish's interpretation based on them.

CT Scans (Considered in Both Claims)

CT scans may be used to diagnose pneumoconiosis and other pulmonary diseases. The regulations provide no guidance for the evaluation of CT scans. They are not subject to the specific requirements for evaluation of x-rays, and must be weighed with other acceptable medical evidence. *Melnick v. Consolidation Coal Co*., 16 B.L.R. 1-31, 1-33-1-34 (1991). The record in this case contains reports of two CT scans, one of the Miner's chest, and another of his abdomen and pelvis, taken in connection with treatment. These two CT scans were ordered by Dr. Parrish. The first scan performed on June 19, 2001, revealed a large mass in the right lung and numerous mediastinal lymph nodes. The scan of the Miner's abdomen and pelvis performed on June 20, 2001, revealed some fibrosis in the lung bases with cystic changes in the right lung base.

Pulmonary Function Studies (Considered in the Miner's Claim)

Pulmonary function studies are tests performed to measure obstruction in the airways of the lungs and the degree of impairment of pulmonary function. The greater the resistance to the flow of air, the more severe the lung impairment. The studies range from simple tests of ventilation to very sophisticated examinations requiring complicated equipment. Tests most often relied upon to establish disability in black lung claims measure forced vital capacity (FVC), forced expiratory volume in one-second (FEV_1) and maximum voluntary ventilation (MVV).

The following chart summarizes the results of the pulmonary function studies available in connection with the Miner's claims. "Pre" and "post" refer to administration of bronchodilators. If only one figure appears, bronchodilators were not administered. In a "qualifying" pulmonary study, the FEV_1 must be equal to or less than the applicable values set forth in the tables in Appendix B of Part 718, and either the FVC or MVV must be equal to or less than the applicable table value, or the FEV_1/FVC ratio must be 55% or less. 20 CFR § 718.204(b)(2)(i) (2006).

Ex. No. Date Physician	Age Height[1]	FEV_1 Pre-/ Post	FVC Pre-/ Post	FEV_1/ FVC Pre-/ Post	MVV Pre-/ Post	Qualify?	Physician Impression
DX 1 04/09/73 Castello	52 73”	3.42	4.63		56.3	No	MVV is diminished due to poor effort. These studies represent a mild obstructive ventilatory defect.
DX 1 10/19/73 Bogartz	53 72.5	2.37	4.66		28	No	Severe obstructive impairment.
DX 1 04/15/80 Swann	59 72”	3.41	4.69		150	No	Normal.
DX 1 06/08/88 Seargeant	67 72”	3.0	4.59	65	90.4	No	
DX 1 06/19/91 Seargeant	71 72	2.28	3.22	71	81.9	No	Mild to moderate COPD.
DX 1 03/16/94 Bruton	73 73”	1.85	3.15	59%		No	Moderate diffuse obstruction.
DX 1 06/06/94 Jordan	73 73”	1.52	2.59	59%		Yes	Worsened since 03/16/94. Not acceptable per Dr. Kraman, only one tracing.
CX 6 09/01/94 Jordan	74 73”	1.68 1.64	3.34 2.94	50% 55%		Yes Yes	
CX 6 06/19/01 Parrish	80 73”	1.85	3.00	62%		No	Moderate obstructive impairment with air trapping

[1] The fact-finder must resolve conflicting heights of the miner recorded on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221, 1-223 (1983); *Toler v. Eastern Assoc. Coal Co.*, 43 F.3d 109, 114, 116 (4th Cir. 1995). As there is a variance in the recorded height of the miner from 69” to 71”, I have taken the mid-point (70”) in determining whether the studies qualify to show disability under the regulations.

Arterial Blood Gas Studies (Considered in the Miner's Claim)

Blood gas studies are performed to measure the ability of the lungs to oxygenate blood. A defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. The blood sample is analyzed for the percentage of oxygen (PO_2) and the percentage of carbon dioxide (PCO_2) in the blood. A lower level of oxygen (O_2) compared to carbon dioxide (CO_2) in the blood indicates a deficiency in the transfer of gases through the alveoli which may leave the miner disabled.

The following chart summarizes the arterial blood gas studies available in connection with the Miner's claim. A "qualifying" arterial gas study yields values which are equal to or less than the applicable values set forth in the tables in Appendix C of Part 718. If the results of a blood gas test at rest do not satisfy Appendix C, then an exercise blood gas test can be offered. Tests with only one figure represent studies at rest only. Exercise studies are not required if medically contraindicated. 20 CFR § 718.105(b) (2006).

Exhibit Number	Date	Physician	PCO_2 at rest/ exercise	PO_2 at rest/ exercise	Qualify?	Physician Impression
DX 1	10/19/73	Bogartz	39.4	75.5	No	Mild hypoxemia.
DX 1	04/15/80	Swann	31.6 27.2	88.3 97.6	No No	PO_2 above normal for age and increased with exercise
DX 1	06/08/88	Seargeant	34 35	75 71	No No	
DX 1	06/19/91	Seargeant	34 35	78 58	No Yes	Test technically acceptable per Dr. Kraman
DX 1	03/16/94	Bruton	37.0	79.5	No	
CX 6	06/25/01	Parrish	31.6	66.3	Yes	
CX 6	08/30/01	Parrish	33.1	64.0	Yes	

Medical Opinions

Medical opinions are relevant to the issues of whether the miner had pneumoconiosis, whether the miner is totally disabled, and whether pneumoconiosis caused the miner's disability and death. The medical opinions must be reasoned and supported by objective medical evidence such as blood gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. 20 CFR § 718.202(a)(4) (2006). With certain specified exceptions not applicable here, the cause or causes of total disability must be established by means of a physician's documented and reasoned report. 20 CFR § 718.204(c)(2) (2006). The cause of death must be proved by competent medical evidence. 20 CFR § 205(c) (2006). The record contains the following medical opinions relating to this case.

Treatment Records (Considered in Both Claims)

The Claimant sought treatment at the East Tennessee Pulmonary Associates in 1994. He saw various doctors in that practice group between 1994 and his death in 2001. Their treatment records are found in DX 1 (up to July 1994) and CX 6.

Dr. Bruton first examined the Miner on March 16, 1994. According to the web-site of the American Board of Medical Specialties,[2] Dr. Bruton is board certified in Internal Medicine and Pulmonary Disease. Dr. Bruton stated that the Miner had been diagnosed with emphysema in 1971 and was a smoker. He took medical, family, social and occupational histories. Dr. Bruton stated that the Miner began smoking at the age of 12 at a rate of one pack per day but currently only smoked a half of a pack per day. He reported that the Miner had 9.5 years of coal mine employment. The chest examination revealed wheezing on inspiration and expiration with a few scattered rales. Dr. Bruton diagnosed chronic obstructive pulmonary disease (COPD) with bronchospasm and possible simple coal workers' pneumoconiosis.

When the Miner returned for follow-up, he was seen by Dr. Jordan. Dr. Jordan first examined the Miner on April 18, 1994. Dr. Jordan is board certified in Internal Medicine, Pulmonary Disease and Critical Care Medicine. He noted a history of moderate obstructive airways disease with evidence of hyperinflation on lung volumes. Dr. Jordan stated that the Miner was still smoking but had cut back to a significant degree. The chest examination was normal.

On May 19, 1994, Dr. Jordan examined the Miner for continued respiratory problems. He stated that the Miner continued to smoke about a half a pack of cigarettes per day. The chest examination revealed a few scattered expiratory wheezes and rhonchus. Dr. Jordan read a chest x-ray as showing pneumoconiosis, ILO Classification 1/0. He opined that the interstitial opacities could be attributed to coal dust exposure or smoking.

Dr. Jordan he examined the Miner again on June 6, 1994. On examination he had prolongation of the expiratory phase, but no wheezing. Pulmonary function testing showed a significant decrease in his FEV_1 and FVC since March. The Miner was still smoking, which Dr. Jordan advised him to quit. Based upon this examination, Dr. Jordan opined that he could not rule black lung out as a possible cause of the Miner's respiratory problems but also opined that the long smoking history could be a cause. He did not think it was worth the risk to have a bronchoscopy.

On June 22, 1994, Dr. Jordan met with the Miner to discuss the risks and benefits of a bronchoscopy with transbronchial biopsy, requested by his attorney in his black lung claim, to see if he had coal workers' pneumoconiosis. Dr. Jordan thought there was a low clinical likelihood of his having the disease.

Dr. Jordon performed a fiberoptic bronchoscopy with transbronchial biopsies in June 1994, and prepared a report dated July 26, 1994. Dr. Jordan saw the Miner concerning the results of his lung biopsy on July 1, 1994. The pathology report showed "mild interstitial fibrosis consistent with COPD, no evidence of any CWP."

[2] Found at http://www.abms.org, visited February 22, 2006.

The Miner was seen by Dr. Jordan on September 1, 1994. Dr. Jordan noted that the Miner had COPD secondary to emphysema. On that day, the Miner presented with "a several day history of increasing cough and shortness of breath." The chest examination revealed expiratory wheezes in all lung fields. A pulmonary function study demonstrated a significant impairment with "no improvement after inhaled bronchodilators." Dr. Jordan diagnosed "bronchospastic exacerbation of . . . obstructive lung disease, possibly secondary to acute bronchitis."

There is a gap in the records from September 1994 to January 1998. On January 29, 1998, the Miner was intubated by Dr. Jordan in order to treat hypoxemic respiratory failure. CX 6. There is no other information about this incident in the record. There is another gap in the records until June 2001.

Dr. Parrish was the Miner's pulmonologist between June and October 2001, when the Miner died. Dr. Parrish is board certified in Internal Medicine, Pulmonary Disease, and Critical Care Medicine. CX 3. He evaluated the Miner on June 19, 2001, on referral from Dr. Burrell, because of a right upper lobe mass. Dr. Burrell's records are not in evidence. Dr. Parrish took the Miner's medical, family, social and occupational histories. He reported that the Miner had smoked for several years and worked as a coal miner. The chest examination revealed hyperinflation but was otherwise normal. Pulmonary function tests showed moderate obstructive impairment with air trapping. Dr. Parrish diagnosed the Miner as suffering from inoperable lung cancer. Bronchoscopy on June 21 was positive for lung cancer. CT scan of the chest showed invasion of the cancer into a rib, as well as an adrenal mass.

The Miner returned to see Dr. Parrish on June 25, 2001. He had symptoms of cough, shortness of breath and sputum production. A chest x-ray showed the mass in the right upper lobe, and revealed infiltrate. The chest examination revealed diffuse wheezes and rales in the right upper lobe. Dr. Parrish's assessment included pneumonia, lung cancer and COPD.

The Miner was hospitalized for pneumonia from June 29 to July 2, 2001. On July 2, 2001, the Miner was discharged from Methodist Medical Center and Dr. Parrish prepared a discharge report. The discharge diagnoses included pneumonia, lung cancer, COPD and coronary artery disease. The chest examination revealed diffuse wheezes and rales in the right lung.

The Miner returned to see Dr. Parrish on July 16, 2001 for follow up care. The chest examination revealed hyperinflation, rales and rhonchi bilaterally. The assessment from this visit was interstitial lung disease bilaterally, 2/1 grade, and coal workers' pneumoconiosis (based upon work history), in addition to his other medical problems. Dr. Parrish told the Miner he would support an application for black lung benefits.

Dr. Parrish examined the Miner on August 30, 2001. He was admitted into the hospital for pain therapy associated with his progressive lung cancer. Dr. Parrish noted a known history of COPD and atherosclerotic cardiovascular disease. The chest examination revealed hyperinflation and rhonchi bilaterally. The assessment included lung cancer, COPD and atherosclerotic cardiovascular disease. On September 3, 2001, the Miner was discharged from the hospital. Dr. Parrish prepared the discharge report. The chest examination revealed rhonchi

bilaterally. Diagnoses included intractable pain due to bone metastasis from lung cancer and COPD.

The Miner returned to Dr. Parrish for follow-up on September 5 and 11, 2001. Dr. Parrish reported that a CT scan on September 11 showed multiple rib destruction, and a right adrenal mass continued to enlarge. He continued to treat the Miner for pain. CX 6.

Death Certificate

The record contains a certified copy of the death certificate for the Miner signed by Dr. Parrish, issued October 29, 2001. DX 12. Dr. Parrish listed the immediate cause of death as lung cancer. Additionally, under "other significant conditions contributing to death," he listed COPD, coronary artery disease, and coal workers' pneumoconiosis (CWP).

Medical Opinions Given in Connection with the Miner's Prior Claims (Considered Only in the Miner's Claim)

The following chart summarizes the medical opinions available in connection with the prior claims.

Date of Treatment, Examination, or Review of Records	Ex. No. Physician Basis for Opinion	Opinion Regarding Existence of Pneumoconiosis	Opinion Regarding Lung Impairment or Disability
10/19/73	DX 1 Bogartz Physical Examination	Chronic bronchitis and obstructive disease; no evidence of pneumoconiosis.	No impairment noted. The Miner should not work in the coal mines.
04/15/80	DX 1 Swann Physical Examination	Bronchitis based upon history. No x-ray evidence of occupational disease of the lungs.	
06/06/88	DX 1 Sexton Treating Physician		Totally disabled based on poor ventilation function.
06/08/88	DX 1 Seargeant Physical Examination	COPD	Nondisabling COPD due to cigarette smoking
06/19/91	DX 1 Seargeant Physical Examination	Mild to moderate COPD due to smoking. No x-ray evidence of pneumoconiosis.	

Medical Opinions Given in Connection with the Pending Claims (Considered in Both Claims)

Dr. Parrish reviewed the Miner's medical records and provided reports dated October 26, 2001, DX 15, June 20, 2002, DX 16, August 14, 2002, DX 16, CX 3, and October 10, 2003, CX 5. In her Evidence Summary Form, the Claimant identified the two most recent as the reports on which she relies. Thus I have not considered the two earlier opinions. The August 2002 report may be considered one of the Claimant's two initial medical opinions; the other is Dr. Sexton's opinion, provided by live testimony at the hearing. Dr. Parrish's October 2003 opinion was given in rebuttal to Dr. Perper's opinion, relied upon by the Director.

In his report dated August 14, 2002, CX 3, Dr. Parrish said that he had met with Dr. Sexton the previous day, and there were several things he thought needed to be pointed out. He said that the Miner's chest x-rays from the previous summer showed large opacities that he graded as category B by the ILO Classification.[3] Additionally, Dr. Parrish stated that the Miner was disabled due to his lung disease with a severe airflow obstruction shown by pulmonary function tests in March 1994. In his opinion, a significant part of the Miner's respiratory impairment was related to coal worker's pneumoconiosis due to his coal mining exposure. More recent pulmonary function tests from June 2001 were similarly reduced, consistent with a moderate obstructive impairment. He concluded that the Miner had significant disability from his coal mining experience based on x-ray, pulmonary function tests and autopsy evidence.

Dr. Perper reviewed the Miner's medical records and provided a report dated April 15, 2002. DX 17. He is board certified in anatomical and surgical pathology and forensic pathology. In his report, Dr. Perper recited the Miner's occupational, smoking and clinical histories, the circumstances of the Miner's death, the autopsy findings, and his own findings upon review of the microscope slides of the Miner's lung, prepared from sections of his lungs taken during the autopsy. Dr. Perper found that these slides demonstrated moderate fibrosis with the presence of focal anthracotic deposits and birefringent silica crystalism carcinoma, numerous silica crystals in anthracotic areas, fibro-anthracosis and metastases of carcinoma. The diagnosis based upon these slides was lung cancer, simple mild coal workers' pneumoconiosis, and severe centrilobular emphysema with focal interstitial fibrosis and bullae. Dr. Perper opined that the Miner suffered from pneumoconiosis which arose from his coal mine employment, despite the fact that he worked in the mines for less than ten years. He said the Miner must have had increased susceptibility to the effects of coal dust. However, he opined that the medical evidence did not support that the Miner's exposure to coal dust or his simple coal workers' pneumoconiosis was a substantial contributory cause of death or a hastening factor in his death. He said that the pneumoconiotic process was not sufficiently marked to conclude that it had direct significance in functional impairment. He said the large nodular lesions had no functional significance. Additionally, Dr. Perper opined that the Miner's primary cause of death was lung cancer and contributing factors were emphysema and heart disease. These diseases are all related to the Miner's long and heavy smoking history. Dr. Perper was not asked, and did not comment, whether the Miner was disabled by a pulmonary or respiratory impairment during his lifetime.

On October 10, 2003, Dr. Parrish prepared a report in rebuttal to Dr. Perper's findings. CX 5. He opined that the Miner was suffering from complicated pneumoconiosis based upon the

[3] Dr. Parrish did not specify to which x-rays he was referring.

autopsy findings showing 1 cm diameter nodules, which is the arbitrary measurement for a diagnosis of fibrosis. Additionally, Dr. Parrish opined that the Miner suffered from centrilobular emphysema, which can be caused by coal dust exposure. He also stated that research has shown that coal dust exposure can cause lung cancer, chronic bronchitis, emphysema, and lung function impairment. Dr. Parrish opined that the Miner's death was "at least in part due to coal workers' pneumoconiosis through the development of emphysema and later lung cancer."

Dr. Sexton was the Miner's family doctor. He testified at the hearing held on March 30, 2005. Dr. Sexton is board certified in Family Practice. He retired from his family practice in 2001, but continued working in long term care, then as medical director of a clinic, and finally accepted a position in an outpatient clinic for the Veterans Administration. In his practice, he treated many coal miners. He began treating the Miner in 1965 for pulmonary illnesses. He had reviewed the Miner's medical records before testifying. Dr. Sexton said the Miner had an active lifestyle in the community, with stable health until his heart attack in 1996. Before that, he had been treated for pulmonary disease from time to time. He said that he and his partner thought that the Miner's exposure to coal dust and silica as a young boy at age 12 or 13 contributed to his pulmonary impairment. Dr. Sexton noted that the Miner told him that he started work earlier than was indicated in his Social Security records, having 11 years of coal mine employment. He also smoked for many years, until his heart attack, which played a part in his development of chronic obstructive lung disease. He said the autopsy report confirmed his opinion that anthrosilicosis played a part in his pulmonary insufficiency for the last 20 years of his life. Dr. Sexton participated in the Miner's terminal care, and conferred with his pulmonologist, Dr. Parrish, and his hospice physician. He testified that the Miner's death was due to metastatic cancer, and that his anthrosilicosis and his smoking history were contributory.

Both Claims: The Miner Had Pneumoconiosis. But Which Type(s)?

The regulations define pneumoconiosis broadly:

> (a) For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical", pneumoconiosis and statutory, or "legal", pneumoconiosis.
>
> (1) Clinical Pneumoconiosis. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconioses, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silico-tuberculosis, arising out of coal mine employment.
>
> (2) Legal Pneumoconiosis. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

(b) For purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

(c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

20 CFR § 718.201 (2006). In this case, the Miner's medical records indicate that he was diagnosed with both simple and complicated pneumoconiosis. In addition, he was diagnosed with chronic obstructive pulmonary disease and emphysema, which can be encompassed within the definition of legal pneumoconiosis. Ibid.; *Warth v. Southern Ohio Coal Co*., 60 F.3d 173 (4th Cir. 1995). However, only chronic obstructive pulmonary disease caused by coal mine dust constitutes legal pneumoconiosis. *Eastover Mining Co. v. Williams*, 338 F.3d 501, 515 (6th Cir. 2003).

20 CFR § 718.202(a) (2006) provides that a finding of the existence of pneumoconiosis may be based on (1) chest x-ray, (2) biopsy or autopsy, (3) application of the presumptions described in Sections 718.304 (irrebuttable presumption that a miner's death was due to pneumoconiosis if there is a showing of complicated pneumoconiosis), 718.305 (not applicable to claims filed after January 1, 1982) or 718.306 (applicable only to deceased miners who died on or before March 1, 1978), or (4) a physician exercising sound medical judgment based on objective medical evidence and supported by a reasoned medical opinion. As this claim is governed by the law of the Sixth Circuit, the Claimant may establish the existence of pneumoconiosis under any one of the alternate methods set forth at Section 202(a). *See Cornett v. Benham Coal Co.*, 227 F.3d 569, 575 (6th Cir. 2000); *Furgerson v. Jericol Mining, Inc.*, 22 B.L.R. 1-216 (2002) (*en banc*). In the case at hand, two out of three of the presumptions do not apply, because the Miner filed his claim after January 1, 1982, and he died after March 1, 1978. The Director has conceded that the Miner had simple clinical pneumoconiosis. I must also consider whether the evidence supports a finding of complicated pneumoconiosis, and whether it supports a finding of legal pneumoconiosis.

Pursuant to Section 718.304(a) the existence of complicated pneumoconiosis may be established when diagnosed by a chest x-ray which yields one or more large opacities (greater than 1 centimeter) and would be classified in Category A, B, or C. X-ray evidence is not the exclusive means of establishing complicated pneumoconiosis under Section 718.304. Its existence may also be established under Section 718.304 (b) by biopsy or autopsy or under Section 718.304 (c), by an equivalent diagnostic result reached by other means. The Benefits Review Board has held that the Administrative Law Judge must first determine whether the relevant evidence in each category tends to establish the existence of complicated pneumoconiosis and then must weigh together the evidence at each subsection before determining whether invocation of the irrebuttable presumption under Section 718.304 has been established. *Melnick v. Consolidated Coal Co*., 16 B.L.R. 1-31, 1-33 (1991) (en banc). The United States Court of Appeals for the Sixth Circuit has held that "[x]-ray evidence of opacities larger than one centimeter does not automatically trigger the irrebuttable presumption when conflicting evidence exists." *Gray v. SLC Coal Co.*, 176 F.3d 382, 388 (6th Cir. 1999).

The autopsy provides conclusive evidence that the Miner had at least simple pneumoconiosis. Every physician who gave an opinion in the current claims agreed on that point. The pathologist who performed the autopsy, Dr. Harrison, described lymph nodes up to 1.8 cm, but did not describe nodules that large. Dr. Perper said specifically that the lymph nodes had no functional impact, and that the autopsy findings documented only simple pneumoconiosis. Dr. Parrish believed the Miner had complicated pneumoconiosis based on his interpretation of the x-ray taken on August 30, 2001 (and on other unspecified x-rays, which I have not considered), and on the autopsy. However, I have found the August 2001 x-ray to be negative for pneumoconiosis. Dr. Parrish also argued that Dr. Harrison's description in the autopsy report of aggregates of anthracotic pigment associated with fibrosis "would almost certainly … be greater than 1 cm." However, Dr. Parrish did not explicitly state that the nodules and fibrosis seen in the autopsy were equivalent to a finding of one or more opacities classifiable as A, B, or C on x-ray. Moreover, Dr. Parrish asked Dr. Harrison to review the slides and measure whether there were "any areas of fibrosis that would meet the criteria for complicated coal workers' pneumoconiosis." No such measurements are in the record, but I infer from Dr. Harrison's letter to Dr. Sexton explaining why nodules measured from autopsy slides might underestimate their size on x-ray, that Dr. Harrison undertook the measurements, and there were none which met the criteria. As the measurements he requested from Dr. Harrison apparently did not support Dr. Parrish's expectation that further review of the autopsy slides would justify a diagnosis of complicated pneumoconiosis, I find that that the autopsy and medical opinions based on it do not support a finding of complicated pneumoconiosis.

As noted above, only one x-ray (submitted for consideration in both current claims) was classified by one reader as showing complicated pneumoconiosis. I have found it to be negative for pneumoconiosis. The current x-ray evidence, therefore, does not support a finding of simple or complicated pneumoconiosis. Moreover, the x-ray evidence from the Miner's previous claims was negative for either simple or complicated pneumoconiosis as well.

Finally, the biopsy evidence (from 2001 in the Survivor's claim, and from 1994 and 2001 in the Miner's claim) does not support a finding of even simple pneumoconiosis.

I conclude that the Claimant has failed to show that the Miner had complicated pneumoconiosis. On the other hand, she has shown the presence of simple clinical pneumoconiosis by virtue of the autopsy and the medical opinions of the physicians who had access to the autopsy report. Indeed, the Director, OWCP, has conceded the presence of simple pneumoconiosis.

I must next consider whether the Claimant has established the presence of legal pneumoconiosis. The Claimant can establish that the Miner suffered from legal pneumoconiosis by well-reasoned, well-documented medical reports. A "documented" opinion is one that sets forth the clinical findings, observations, facts, and other data upon which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). An opinion may be adequately documented if it is based on items such as a physical examination, symptoms, and the patient's work and social histories. *Hoffman v. B&G Construction Co.*, 8 B.L.R. 1-65, 1-66 (1985); *Hess v. Clinchfield Coal Co.*, 7 B.L.R. 1-295, 1-296 (1984); *Justus v. Director, OWCP*, 6 B.L.R. 1-1127, 1-1129 (1984). A "reasoned" opinion is one in which the judge finds the underlying documentation and data adequate to support the physician's conclusions. *Fields*, above. Whether a medical report is sufficiently documented and reasoned is for the judge to

decide as the finder-of-fact; an unreasoned or undocumented opinion may be given little or no weight. *Clark v. Karst-Robbins Coal Co*., 12 B.L.R. 1-149, 1-155 (1989) (en banc).

The Department of Labor has taken the position that coal dust exposure may induce obstructive lung disease even in the absence of fibrosis or complicated pneumoconiosis. This underlying premise was stated explicitly in the commentary that accompanied the final version of the current regulations. The Department concluded that "[e]ven in the absence of smoking, coal mine dust exposure is clearly associated with clinically significant airways obstruction and chronic bronchitis. **The risk is additive with cigarette smoking**." 65 Fed. Reg. at 79940 (emphasis added). Citing to studies and medical literature reviews conducted by NIOSH, the Department quoted the following from NIOSH:

> … COPD may be detected from decrements in certain measures of lung function, especially FEV1 and the ratio of FEV1/FVC. **Decrements in lung function associated with exposure to coal mine dust are severe enough to be disabling in some miners, whether or not pneumoconiosis is also present**.…

65 Fed. Reg. at 79943 (emphasis added). Moreover, the Department concluded that the medical literature "support[s] the theory that dust-induced emphysema and smoke-induced emphysema occur through similar mechanisms." I have considered how to weigh the conflicting medical opinions in this case based on these principles.

The qualifications of the physicians are relevant in assessing the respective probative values to which their opinions are entitled. *Burns v. Director, OWCP*, 7 B.L.R. 1-597, 1-599 (1984). More weight may be accorded to the conclusions of a treating physician as he or she is more likely to be familiar with the miner's condition than a physician who examines him episodically. *Onderko v. Director, OWC*P, 14 B.L.R. 1-2, 1-6 (1989). However, a judge "is not required to accord greater weight to the opinion of a physician based solely on his status as the Claimant's treating physician. Rather, this is one factor which may be taken into consideration in … weighing … the medical evidence …" *Tedesco v. Director, OWCP*, 18 B.L.R. 1-103, 1-105 (1994). Factors to be considered in weighing evidence from treating physicians include the nature and duration of the relationship, and the frequency and extent of treatment. In appropriate cases, a treating physician's opinion may be give controlling weight, provided that the decision to do so is based on the credibility of the opinion "in light of its reasoning and documentation, other relevant evidence and the record as a whole." 20 CFR § 718.104(d) (2006). The Sixth Circuit has interpreted this rule to mean that

> in black lung litigation, the opinions of treating physicians get the deference they deserve based on their power to persuade … For instance, a highly qualified treating physician who has lengthy experience with a miner may deserve tremendous deference, whereas a treating physician without the right pulmonary certifications should have his opinions appropriately discounted. The case law and applicable regulatory scheme make clear that ALJs must evaluate treating physicians just as they consider other experts.

Eastover Mining Co. v. Williams, 338 F.3d 501, 513 (6th Cir. 2003) (citations omitted).

I have considered the medical opinion evidence admitted in the current claims in deciding both the Miner's and the Survivor's claims. I have considered the medical opinion evidence admitted in the Miner's prior claims only in the Miner's pending claim.

As to the medical opinion evidence in the current claims, two of the Miner's treating physicians, Dr. Parrish and Dr. Sexton, said that the Miner had an obstructive impairment demonstrated by pulmonary function tests, and that coal dust exposure contributed to that impairment. Dr. Harrison, too, associated the Miner's "marked emphysema" with his anthracosilicosis. I construe these three opinions to constitute a diagnosis of legal pneumoconiosis. Dr. Parrish is a board-certified pulmonologist, was very familiar with the Miner's condition during the last months of his life, and had access to the Miner's treatment records back to at least 1994, when the Miner first received treatment from the East Tennessee Pulmonary Associates. He was familiar with the Miner's extensive smoking history, and his limited history of coal mine employment. Thus I find that his opinion is entitled to great weight on the issue of legal pneumoconiosis. Dr. Sexton, although not a pulmonologist, is board certified in family practice and had extensive experience treating coal miners. He had been the Miner's doctor since 1965. He, too, was familiar with the Miner's pertinent history. I also give his opinion great weight. Dr. Harrison is a board certified pathologist, and therefore well qualified to render an opinion on autopsy. It is unclear from his report, however, whether he knew of the Miner's smoking history. Nonetheless, I also give probative weight to his report on this issue, based on his observations during the autopsy.

Of his treating physicians, only Dr. Jordan, who saw the Miner several times in 1994, attributed his obstructive impairment entirely to smoking. However, Dr. Jordan's biopsy had failed to detect the presence of coal worker's pneumoconiosis, which was later found to be present on autopsy. Moreover, as Dr. Perper observed, the fact that the Miner had less than 10 years of coal mine employment made it less likely that he would develop pneumoconiosis. Nonetheless, as the autopsy showed, he had developed it. Thus, although Dr. Jordan's diagnosis was based on the best evidence available to him at the time, it was later proved to be incorrect. Dr. Perper himself appears to have addressed only clinical pneumoconiosis in his report. He did not comment on what caused the Miner's emphysema. Based on the medical evidence submitted in the pending claims, I find that the Claimant has established that the Miner had legal pneumoconiosis.

Adding the medical opinion evidence admitted in the Miner's prior claims into consideration does not undermine the conclusion that the Miner had legal pneumoconiosis. Every doctor who offered an opinion on the Miner's pulmonary condition in the prior claims said that he had bronchitis and/or chronic obstructive disease. None said that his coal mine employment contributed to the disease. Dr. Seargeant, in particular, who examined the Miner in 1988 and 1991, found no pneumoconiosis, and attributed the Miner's COPD entirely to smoking. However, later evidence showed that the Miner did, in fact, develop pneumoconiosis. Because Dr. Sergeant's opinions were remote in time, I give them little weight. The opinions given in 1973 and 1980 being even more remote, they carry even less weight.

Considering the medical opinion evidence admitted into the Survivor's claim, and the medical opinion evidence admitted into all of the Miner's claims, I conclude that the Claimant has established that the Miner had both simple clinical pneumoconiosis, and legal pneumoconiosis, for the purpose of both claims.

Both Claims: Whether There Was a Causal Relationship Between the Miner's Pneumoconiosis and His Coal Mine Employment

The Act and the regulations provide for a rebuttable presumption that pneumoconiosis arose out of coal mine employment if a miner with pneumoconiosis was employed in the mines for ten or more years. 30 U.S.C. § 921(c)(1); 20 CFR § 718.203(b) (2006). The Claimant was employed as a miner for only six years, and therefore is not entitled to the presumption. Nonetheless, based on the autopsy and the opinions of Drs. Parrish, Sexton, Harrison and Perper, I conclude that the Claimant's pneumoconiosis was caused by his coal mine employment. Recently the 10th Circuit Court of Appeals held that the presumption applies only when the miner has established that he has clinical pneumoconiosis. *Anderson v. Director, OWCP*, 455 F.3d 1102 (10th Cir. 2006). In this case, I have found that the Claimant has established that he has both legal and clinical pneumoconiosis. I also find that he has established a causal relationship between his chronic obstructive pulmonary disease and his coal mine employment through the opinions of Drs. Parrish, Sexton and Harrison.

The Miner's Claim: Total Pulmonary or Respiratory Disability

A miner is considered totally disabled if he has complicated pneumoconiosis, 30 U.S.C. § 921(c)(3), 20 CFR § 718.304 (2006), or if he has a pulmonary or respiratory impairment to which pneumoconiosis is a substantially contributing cause, and which prevents him from doing his usual coal mine employment and comparable gainful employment, 30 U.S.C. § 902(f), 20 CFR § 718.204(b) and (c) (2006). The regulations provide five methods to show total disability other than by the presence of complicated pneumoconiosis: (1) pulmonary function studies; (2) blood gas studies; (3) evidence of cor pulmonale; (4) reasoned medical opinion; and (5) lay testimony. 20 CFR § 718.204(b) and (d) (2006). I have determined that the Claimant has not shown that the Miner suffered from complicated pneumoconiosis. There is no evidence in the record that the Miner suffered from cor pulmonale. Thus I will consider pulmonary function studies, blood gas studies and medical opinions. In the absence of contrary probative evidence, evidence from any of these categories may establish disability. If there is contrary evidence, however, I must weigh all the evidence in reaching a determination whether disability has been established. 20 CFR § 718.204(b)(2) (2006); *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-21 (1987); *Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195, 1-198 (1986).

Of the nine pulmonary function tests in the record, only two taken in 1994 resulted in values qualifying to show disability, and the most recent test, administered in 2001, did not. I find that the Claimant has failed to establish total disability based on the pulmonary function tests.

As to the arterial blood gas studies, the only exercise study, administered in 1991, and the two most recent studies at rest, administered in 2001, resulted in values qualifying for disability. An intervening study at rest, from 1994, did not qualify, but there was no exercise study taken at that time. I find that the arterial blood gas studies support the conclusion that the Miner was totally disabled. I note that the arterial blood gas studies measure a different aspect of lung function than do pulmonary function tests, so the differing conclusions to not represent a conflict in the evidence.

The only medical opinions regarding total disability submitted in the current claims were those by Dr. Parrish and Dr. Sexton opining that the Miner was totally disabled by a pulmonary impairment. There were no contrary opinions offered. Neither Dr. Jordan, nor Dr. Harrison, nor Dr. Perper, expressed any opinion on whether or not the Miner was disabled during his lifetime. The most recent opinion that the Miner was not disabled found in the prior claims was Dr. Sergeant's, from 1988. That opinion is too remote in time to be of any significance. Dr. Seargeant did not give an opinion regarding the Miner's disability in 1991, noting on his report only that the Miner was already retired.

I find that the Claimant has established that during his lifetime, the Miner was totally disabled due to a pulmonary or respiratory impairment based on the arterial blood gas studies and the medical opinion evidence.

The Miner's Claim: Causation of Total Disability

In order to be entitled to benefits, the Claimant must establish that pneumoconiosis is a "substantially contributing cause" to the miner's disability. A "substantially contributing cause" is one which has a material adverse effect on the miner's respiratory or pulmonary condition, or one which materially worsens another respiratory or pulmonary impairment unrelated to coal mine employment. 20 CFR § 718.204(c) (2006); *Tennessee Consol. Coal Co. v. Kirk*, 264 F.3d 602, 610 (6th Cir. 2001). Dr. Parrish and Dr. Sexton were both of the opinion that coal dust exposure contributed to the Miner's disability. There is no contrary evidence. I find that the Claimant has established that coal dust exposure was a substantially contributing cause to the Miner's disability.

Date of Entitlement in the Miner's Claim

In the case of a miner who is totally disabled due to pneumoconiosis, benefits commence with the month of onset of total disability. Medical evidence of total disability does not establish the date of entitlement; rather, it shows that a claimant became disabled at some earlier date. *Owens v. Jewell Smokeless Coal Corp.*, 14 BLR 1-47, 1-50 (1990). Where the evidence does not establish the month of onset, benefits begin with the month that the claim was filed, unless the evidence establishes that the miner was not totally disabled due to pneumoconiosis at any subsequent time. 20 CFR § 725.503(b) (2006); *Harris v. Old Ben Coal Co.*, 23 B.L.R. 1-___, BRB No. 04-0812 BLA (Jan. 27, 2006), slip op. at 17.

The Claimant filed his claim for benefits in August 2001. Dr. Sexton said that the Claimant was totally disabled due to a ventilatory impairment in 1988. Dr. Seargeant obtained a qualifying exercise arterial blood gas value in 1991; he did not comment on whether the Miner was disabled, stating only that the Miner was retired at the time of his examination. Dr. Parrish said that the Miner was disabled by March 1994, based on the results of pulmonary function tests administered during treatment by his practice group. Dr. Perper did not give an opinion regarding disability. Thus the uncontradicted medical evidence suggests that the Claimant was totally disabled before Judge Teitler issued his decision. However, Judge Teitler did not address whether the Miner was disabled by a pulmonary or respiratory impairment, as he found that the Miner did not establish that he had pneumoconiosis. Moreover, the regulation regarding subsequent claims also provides, "In any case in which a subsequent claim is awarded, no benefits may be paid for any period prior to the date upon which the order denying the prior

claim became final." 20 CFR § 725.309(d)(5). Judge Teitler issued his proposed decision and order on the Miner's previous claim on March 2, 1995. As the Miner took no further action on that claim, it became final one year later, on March 2, 1996.

I find that the Miner was entitled to benefits commencing in March 1996, when the decision on his previous claim became final.

The Survivor's Claim: Death Due to Pneumoconiosis

In claims filed after January 1, 1982, death will be considered to be due to pneumoconiosis if (1) competent medical evidence establishes that the miner's death was due to pneumoconiosis; (2) pneumoconiosis was a substantially contributing cause or factor leading to the miner's death or the death was caused by complications of pneumoconiosis; or (3) the presumption set forth at 20 CFR § 718.304 applies, i.e., an irrebuttable presumption that death was due to pneumoconiosis where there is medical evidence of complicated pneumoconiosis; but not if (4) the miner's death was caused by a traumatic injury or the principal cause of death was a medical condition not related to pneumoconiosis, unless the evidence establishes that pneumoconiosis was a substantially contributing cause of death. 20 CFR § 718.205(c) (2006). The Sixth Circuit, in which this claim arises, has held that any condition that hastens the miner's death is a substantially contributing cause of death. *Brown v. Rock Creek Mining Corp*., 996 F.2d 812 (6th Cir. 1993). This principle has now been codified in the regulations at 20 CFR § 718.205(c)(5) (2006). Nevertheless, a claimant must still prove that pneumoconiosis has "hastened" death by a "a specifically defined process that reduces the miner's life by an estimable time"; the basis for finding that pneumoconiosis contributed to a miner's death may not be simply that the disease made a miner weaker and, thus, less resistant to some other trauma that directly caused the death. *Eastover Mining v. Williams*, 338 F.3d 501, 517-518 (6th Cir. 2003).

Dr. Perper diagnosed simple clinical pneumoconiosis based on the autopsy. However, he said that the Miner's pneumoconiosis did not hasten his death. On the other hand, Dr. Perper did identify emphysema as a contributing factor to the Miner's death. A careful reading of Dr. Perper's report supports the conclusion that in rendering his opinion, he considered only the effects of clinical pneumoconiosis, but not the effects of legal pneumoconiosis. Dr. Parrish and Dr. Sexton both diagnosed legal as well as clinical pneumoconiosis, and each said that one or the other type of pneumoconiosis contributed to the Miner's death. As the Miner's treating physicians, Drs. Parrish and Sexton were in a better position than Dr. Perper to evaluate the Miner's pulmonary condition, and whether and how it contributed to his death. Moreover, to the extent that Dr. Perper believed that emphysema hastened the Miner's death, his opinion supports those of the treating physicians. I give greatest weight to the treating physicians' opinions, and find that the Claimant has established that the Miner's pneumoconiosis hastened his death within the meaning of the statute and regulations.

FINDINGS AND CONCLUSIONS REGARDING ENTITLEMENT TO BENEFITS

Having considered all of the relevant evidence admitted into evidence in the Miner's claim, I find that the Claimant has established that the Miner had pneumoconiosis arising out of his coal mine employment, and a totally disabling pulmonary or respiratory impairment caused by pneumoconiosis. Thus the Claimant has met her burden of showing a change in an applicable

condition of entitlement pursuant to § 725.309(d). Accordingly, Miner was entitled to benefits under the Act from March 1996 until his death, augmented for the Claimant, his sole dependent.

I also find that the Claimant has established that pneumoconiosis hastened the Miner's death within the meaning of the Act and the regulations. Thus the Claimant is entitled to benefits as the survivor of the Miner.

ATTORNEY FEES

The regulations address attorney's fees at 20 CFR §§ 725.362, 365 and 366 (2006). The Claimant's attorney has not yet filed an application for attorney's fees. The Claimant's attorney is hereby allowed thirty days (30) days to file an application for fees. A service sheet showing that service has been made upon all parties, including the Claimant, must accompany the application. The Director shall have ten (10) days following service of the application within which to file any objections, plus five (5) days for service by mail, for a total of fifteen (15) days. The Act prohibits the charging of a fee in the absence of an approved application.

ORDER

The claim for benefits filed by the Miner on August 21, 2001, is hereby GRANTED. The claim for benefits filed by the Claimant on December 28, 2001, is also GRANTED.

A

ALICE M. CRAFT
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).